CHAPTER 2-000 PROVIDER PARTICIPATION

2-001 Provider Eligibility

2-001.01 Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department.

2-001.02 Eligibility: To be eligible to participate in the Nebraska Medical Assistance Program (NMAP), the provider shall meet the general standards for all providers in Chapters 1-000, 2-000, and 3-000 of this title, if appropriate, and the standards for participation for that provider type. The standards for participation are listed in each provider chapter of this title; in Title 480 NAC for home and community-based waiver services; and in Title 482 for managed care services. The Department shall not pay a provider who is required to be licensed and/or certified but who is not licensed and/or certified at the time of service.

2-001.02A Denial of Provider Agreement for Good Cause: The Department may refuse to execute, or may cancel, a provider agreement with a provider when there is demonstratable good cause. Good cause is, defined as but is not limited to -

1. The provider does not meet the standards for participation required by the Nebraska Medical Assistance Program (NMAP) which are listed in the appropriate chapter of Titles 471, 480, and/or 482 for each type of service; or
2. The provider, or an employee of the provider, has been excluded, sanctioned, or terminated from participation by Medicare or Medicaid in Nebraska or another state (see 471 NAC 2-002).

No provider agreement will be issued or remain in effect if there is a conviction for, admission of, or substantial evidence of crimes against a child or vulnerable adult, crimes involving intentional bodily harm, crimes involving the illegal use of a controlled substance, or crimes involving moral turpitude on the part of the provider or any other household members. The provider and household members shall not engage in or have a history of behavior injurious to or which may endanger the health or morals of the client.

2-001.03 Provider Agreements: Each provider is required to have an approved agreement with the Department. By signing the agreement, the provider agrees to -

1. Fully meet standards established by the federal Department of Health and Human Services, and any applicable state and federal laws governing the provision of their services;
2. Provide services according to the regulations and procedures of the Department for NMAP;
3. Provide services in compliance with Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973;

4. Accept as payment in full the amount paid in accordance with the rates established by the Department after all other sources (including third party resources, Medicare, or excess income) have been exhausted. Exception: If a client resides in a nursing facility, a payment to the facility for the client to occupy a single room is not considered income in the client's budget if Medicaid is or will be paying any part of the nursing facility care;
5. Submit charges to the Department which do not exceed the provider's charges to the general public;
6. Submit claims which are true, accurate, and complete;
7. Maintain records on all services provided for which a claim has been made, and furnish, on request, the records to the Department, the federal Department of Health and Human Services, and the federal or state fraud and abuse units. Providers shall document services rendered in an institutional setting in the client's institutional chart before billing the Department;
8. Submit claims electronically, if applicable, under proper signature of the provider or the provider's authorized representative;
9. Maintain computer software used in the submission of claims and furnish, on request, the documentation to the Department, the federal Department of Health and Human Services and the federal or state fraud and abuse units;
10. Follow the submittal procedures, record layout requirements, service verification requirements, and provider and/or authorized representative certification requirements for the electronic submission of claims; and
11. A provider shall not establish a policy to automatically waive copayment or deductibles established by the Department.

Failure to meet these requirements may result in termination or suspension of the provider agreement (see 471 NAC 2-002).

Signing the provider agreement and enrolling in NMAP does not constitute employment.

2-001.03A Signature Date of Provider Agreement: A provider agreement must be signed and on file with the Department before payment for services is made. Payment may be made for covered services provided before the signature date of the agreement if the agreement is signed and on file with the Department before payment and the provider met all eligibility requirements at the time the service was provided.

2-001.03B Required Forms: Providers shall complete the appropriate form listed below and submit the signed form to the Department:

1. Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90);
2. Form MC-20, "Medical Assistance Hospital Provider Agreement" (see 471-000-91); or
3. Form MC-81, "Medical Assistance SNF/ICF/ICF-MR Provider Agreement," (see 471-000-104).

Certain providers of home and community-based services are required to complete provider agreement forms as indicated in Title 480. Certain providers of medical transportation services are required to complete the provider agreement form as indicated in Titles 473 and 474.

The Department does not accept provider agreements that have been altered in any way. An altered agreement will be returned to the potential/current provider; a new agreement will be required or participation in NMAP will be terminated.

NMAP may require a new agreement to update information and/or eligibility. The appropriate form will be required to secure and maintain an updated agreement on file for each provider. If an updated agreement is requested by the Department, the provider shall complete and sign the updated agreement.

2-001.03C Approval and Enrollment: Submitted provider agreements are reviewed before approval and enrollment. A Medicaid provider number is assigned. This number is used for billing Medicaid.

2-001.04 Standards for Participation: Providers shall meet the following minimum standards:

1. Accept the philosophy of service provision which includes acceptance of, respect for, and a positive attitude toward Medicaid clients and the philosophy of client empowerment;
2. Meet any applicable licensure or certification requirements and maintain current licensure or certification;
3. Obtain adequate information on the medical and personal needs of each client, if applicable;
4. Not discriminate against any client, employee, or applicant for employment because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90, and 41 CFR Part 60;
5. Agree to a law enforcement check and Adult Protective Services and Child Protective Services Central Registry checks;
6. Operate a drug-free workplace;
7. Attend training on the NMAP as deemed necessary by the Department;
8. Provide services within the scope of practice under applicable licensure or certification requirements; and
9. Agree to maintain up-to-date and accurate provider agreement information by submitting any changes to the Department.

Employees of providers are subject to the same standards.

2-001.05 Employees as Providers: No employee of the Department and its subdivisions, except clinical consultants, may serve as providers of medical services under the Nebraska Medical Assistance Program or as paid consultants to providers under the Nebraska Medical Assistance Program without the express written approval of the Director.

2-001.06 Principles of Providing Medical Assistance: Medical care and services are provided through NMAP to maintain good physical and mental health, to prevent physical disease and disability, to mitigate disease, and to rehabilitate the individual. The amount and type of service required is defined for each case through utilization review. The provider shall limit services to essential health care. The plan for providing services within program guidelines through NMAP is based on the following principles:

1. All plans for medical care must provide for essential health services and for integration of treatment with social planning to reduce economic dependency;
2. Medical care and services must be coordinated with health services available through existing public and private sources;
3. Medical care and services must be provided as economically as is consistent with accepted standards of medical care and fair compensation to providers;
4. Medical care and services must be within the licensure of the provider giving the care or service; and
5. The client must be allowed, within these limitations, to exercise free choice in the selection of a qualified provider.

2-001.07 Provider Handbooks: The Department issues provider handbooks for specific provider types addressed in this Title. Each provider handbook contains -

1. Chapters 1-000, 2-000, and 3-000 of Title 471;
2. The appropriate provider chapter; and
3. Instructions for forms and electronic transactions.

While the handbooks contain policy related to specific provider groups, they may not contain all rules and regulations of NMAP for all possible circumstances. In these cases, regulations contained in the Nebraska Department of Health and Human Services Finance and Support Manual will prevail. The individual provider is responsible for ensuring that s/he has an up-to-date provider handbook, that s/he has all applicable rules and regulations, and that employees, consultants, and contractors are informed about the regulations of this program.

2-001.08 Provider Bulletins: The Medicaid Division may issue provider bulletins to inform providers of regulation interpretations.

2-001.09 Electronic Information Exchange: Any entity that exchanges standard electronic transactions with the Department must have an approved trading partner agreement with the Department.

2-002 Administrative Sanctions

2-002.01 Purpose: This section -

1. Establishes the basis on which certain claims for NMAP services or merchandise will be determined to be false, fraudulent, abusive, or in violation of NMAP policies, procedures, and regulations;
2. Lists the sanctions which may be imposed; and
3. Describes the method of imposing the sanctions.

The Surveillance and Utilization Review (SURS) Unit in the Medicaid Division has responsibility for these functions.

2-002.02 Definitions: The following definitions apply within this section:

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Nebraska Medical Assistance Program (NMAP) or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. This may include under-utilization, lack of treatment, or lack of appropriate referrals. Abuse also includes client practices that result in unnecessary cost to NMAP.

Affiliates: Persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

Billing: Presenting, or causing to be presented, a claim for payment to the Department, its agents, or assignees.

Billing Agent: An entity that submits or facilitates the submission of claims for payment to the Department.

Claim: A request for payment for services rendered or supplied by a provider to a client.

Clearinghouse: An entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or data content for a receiving entity.

Closed-End Provider Agreement: An agreement that is for a specific period of time that must be renewed to allow the provider to continue to participate in NMAP.

Excluded Person: Any person who has been formally denied enrollment or continued participation in NMAP.

Exclusion: Denial of enrollment or continued participation in NMAP.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Fraud includes, but is not limited to, the willful false statement or representation, or impersonation or other device, made by a client or applicant, provider, Departmental employee, or any other person, for the purpose of obtaining or attempting to obtain, or aiding or abetting any person to obtain -

1. An assistance certificate of award to which s/he is not entitled;
2. Any commodity, food stuff, food coupon, or payment to which the individual is not entitled or a larger amount of payment than that to which the individual is entitled;
3. Any payment made on behalf of a client of medical assistance or social services;
4. Any other benefit administered by the State of Nebraska, its agents or assignees; or
5. Assistance in violation of any statutory provision relating to programs administered by the Nebraska Department of Health and Human Services Finance and Support.

NHC: The Nebraska Health Connection (Medicaid managed care) (see Title 482 NAC).

NMMCP: The Nebraska Medicaid Managed Care Program (see Title 482 NAC).

Open-Ended Provider Agreement: An agreement that has no specific termination dates and continues in force as long as it is agreeable to both parties.

Overutilization: A documented pattern of ordering or performing and billing tests, examinations, medical visits, and/or surgeries, drugs and merchandise for which there is no demonstrable need, when the determination of demonstrable need is made by the Medicaid Medical Director or consultants.

Participation: Participation in NMAP includes providing, referring, furnishing, ordering, or prescribing services to a Medicaid client or causing services to be provided, referred, furnished, ordered, or prescribed for a Medicaid client.

Payment: Reimbursement or compensation by the Department, its agents, or assignees, e.g., managed care plans.

Person: Any individual, company, firm, association, corporation, or other legal entity.

Provider: Any person which furnishes Medicaid goods or services under an approved provider agreement with the Department.

Proper Patient Waiver: An agreement by which the client or client's legal representative agrees to release his/her medical records to state or federal authorities accomplished by the client signing Form DA-100, "Application for Assistance."

Suspension from Participation: An exclusion from participation in NMAP for a specified period of time.

Suspension of Payments: Withholding of payments due a provider until the resolution of the matter in dispute between the provider and the Department.

Termination from Participation: A permanent exclusion from participation in NMAP.

Trading Partner Agreement (TPA): An agreement related to the electronic exchange of information.

Trading Partner: A health care plan, provider or clearinghouse that transmits any health information in electronic form.

Underutilization: Lack of treatment/referrals when there is a demonstrable need, when the determination of demonstrable need is made by the Medicaid Medical Director or consultants.

Usual and Customary Charge: Charge to the general public.

Withholding of Payments: A reduction or adjustment of the amounts paid to the provider on pending and subsequently submitted claims to offset overpayments previously made to the provider.

2-002.03 Reasons for Sanctions: The grounds for the Department to impose sanctions upon a provider include, but are not limited to, the following:

1. Presenting, or causing to be presented, any false or fraudulent claim for goods or services or merchandise for payment;
2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater payment than that to which the provider is legally entitled;
3. Billing in excess of the usual and customary charges;
4. Altering medical records to obtain a higher classification of the client than is truly warranted;
5. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization/approval requirements, or obtaining payments prior to the effective date;
6. Failing to disclose or make available to the Department, or its authorized representatives, records of services provided to NMAP clients and records of payments by the Department, its agents and others made for those services, when requested;
7. Failing to provide and maintain quality, necessary, and appropriate services within accepted medical standards as determined by a body of peers, as documented by repeat deficiencies noted by the survey and certification agency, a peer review committee, medical review teams, or independent professional review teams, or by the determination of the Medicaid Director and/or consultants, or the Department or its designee, the Department's Quality Assurance Committee, any Department Inspection of Care, or a managed care plan's quality assurance committee;

8. Breaching the terms of the Medicaid provider agreement or submitting false or fraudulent application for providing participation;
9. Violating any provision of the Nebraska laws regarding NMAP or any rule or regulation of NMAP;
10. Failing to comply with the terms of the provider certification on the Medicaid claim form;
11. Overutilizing the Medicaid program by inducing, furnishing, or otherwise causing a client to receive services or merchandise not otherwise required by the client, ordered by the attending physician, or deemed appropriate by utilization review committee. Note: A determination of overutilization may be based on a comparison of treatment practices of a specific provider compared to peers for similar types of clients;
12. Underutilizing the Medicaid program by not furnishing required services;
13. Presenting a claim, billing, or causing a claim to be presented for payment for services not rendered (including "no-shows");
14. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
15. Soliciting, offering, or receiving a kickback, bribe, or rebate;
16. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries;
17. Failing to meet standards required by state or federal law for participation (e.g., licensure and/or certification);
18. Not accepting Medicaid payment as payment in full for covered services and collecting or attempting to collect additional payment from others, the client or responsible person, or collecting a portion of the service fee from the client or the client's family, except for required co-payments;
19. Refusing to execute a new provider agreement at the Department's request, failing to update as required in 471 NAC 20-001.09C, 32-004.03A, and 35-002 or failing to update provider agreement information when changes have occurred;
20. Failing to correct deficiencies in operations or improper billing practices after receiving written notice of these deficiencies/practices from the Department or its agent (for example, HHS Regulation and Licensure for home and community-based waivers, managed care plans);
21. Being formally reprimanded or censured by an association of the provider's peers for unethical practices;
22. Being suspended or terminated from participation in another governmental medical program such as Worker's Compensation, Medically Handicapped Children's Program, Vocational Rehabilitation Services, Medicare, or Medicaid in another state or a Medicaid managed care plan; being convicted for civil or criminal violations of NMAP, or any other state's Medicaid (medical assistance) program; or having sanctions applied by the Department's agents or assignees or any other state's Medicaid program;
23. Failing to repay or make arrangements for the repayment of overpayments or otherwise erroneous payments;

24. Submitting duplicate bills, including billing NMAP twice for the same service, or billing both NMAP and another insurer or government program;
25. Billing before the goods or services are provided or dispensed prior to the date of billing (pre-billing);
26. Any action resulting in a reduction or depletion of a nursing facility or ICF/MR Medicaid client's personal allowance funds or reserve account (liquid assets) unless specifically authorized in writing by the client, or legal representative;
27. Billing for services provided by non-enrolled providers, sanctioned providers, or excluded persons;
28. Billing for services rendered by someone else as though the provider performed the services him/herself;
29. Billing for services provided by an individual who is required to be licensed or certified and who did not meet that requirement when the service was provided;
30. Billing for services provided outside the provider's scope of practice;
31. Upgrading services billed and rendered from those actually ordered;
32. Upcoding services billed or billing a higher level of service than those actually provided;
33. Reporting of unallowable cost items on a provider's cost report or reporting any item which is obviously unallowable except when the unallowable entry was included in the cost report only to establish a basis for appeal;
34. Violating conditions of an exclusion;
35. Violating conditions of probationary or restricted licensure;
36. Not having the appropriate Drug Enforcement Administration (DEA) license or state drug license;
37. Loss, restriction, or lack or hospital privileges;
38. Failure or inability to provide and maintain quality, necessary and appropriate services due to physical or mental health conditions of the service provider;
39. Endangering health and safety of clients;
40. Failure to obtain or maintain required surety bond(s);
41. Failure to provide Department with documentation of authorization for third party to submit claims for the provider for payment to the Department or failing to update this information when changes have occurred; or
42. Breaching the terms of a Trading Partner Agreement to exchange information electronically.

2-002.04 Sanctions: The Department may invoke one or more of the following sanctions against a provider based on 471 NAC 2-002.03:

1. Termination from participation in the Medicaid program;
2. Suspension of participation in the Medicaid program;
3. Suspension or termination of participation in the NMMCP (NHC);
4. Suspension or withholding of payments to a provider;
5. Recoupment from future provider payments;
6. Transfer to a closed-end provider agreement not to exceed 12 months, or the shortening of an already existing closed-end provider agreement; or
7. Attendance at provider education sessions.

2-002.04A Excluded Persons: The Department may exclude non-participating persons based on 471 NAC 2-002.03; this includes, but is not limited to, billing agents, clearinghouses, and accountants.

2-002.05 Imposition of a Sanction: The decision on the sanction to be imposed is at the discretion of the Director. The following factors are considered in determining the sanctions to be imposed:

1. Seriousness of the offenses;
2. Extent of violations;
3. History of prior violations;
4. Prior imposition of sanctions;
5. Prior provision of provider education;
6. Provider willingness to comply with program rules;
7. Whether a lesser sanction will be sufficient to remedy the problem; and
8. Actions taken or recommended by peer review groups and licensing boards.

The Department shall notify the provider at least 30 days before the effective date of the sanction, unless extenuating circumstances exist. The Department shall give the provider an opportunity to submit additional information or to appeal the sanction. The provider must file the appeal within 30 days of the date of the notice of the sanction. When the clients' health and safety is threatened, appropriate administrative sanctions may be taken without a full evidentiary hearing. The provider may file an appeal regarding this action; however, the sanction will remain in effect until the hearing decision is made. When a sanction is imposed, the Department shall give general notice to the public of the restriction, its basis, and its duration.

To prevent inappropriate Medicaid payments or to avoid further overpayments, the Department may sanction a provider by suspending the provider's payments with an immediate effective date. The Department will notify the provider by letter that its payments have been suspended. The provider may file an appeal regarding this action; however, the suspension of payments will remain in effect until the hearing decision is made.

If a provider participates under one or more provider number, or changes numbers, payments can be suspended, withheld or recouped from one or all of the provider numbers.

2-002.05A Conditions of Suspension or Termination: When a provider is suspended or terminated from NMAP, NMAP may not make reimbursement for services, items, or drugs that are provided, referred, furnished, or prescribed by the suspended or terminated provider or caused to be provided, referred, furnished, ordered, or prescribed for a Medicaid client.

A Medicaid client may not be billed for any services provided, referred, furnished, ordered, or prescribed by an excluded provider.

Exception: NMAP may pay claims from a submitting provider, such as a pharmacy, until the submitting provider and the client are notified of the suspension or termination of the prescribing/attending provider. NMAP may pay claims for emergency medical services when Medicaid Division staff or consultants determine that the services were medically necessary.

2-002.05B Sanction of Affiliates: The Department may sanction all known affiliates of a provider when each decision to include an affiliate is made on a case by case basis after considering all relevant facts and circumstances. The Department may determine the affiliate's violation, failure, or inadequacy of performance when the provider's action which resulted in a sanction took place in the course of the affiliate's official duty or with the knowledge or approval of the affiliate.

2-002.05C Claims Submitted by an Excluded Provider: Suspension or termination from participation of any provider shall preclude the provider from submitting claims for payment, either personally or through any clinic, group, corporation, or other association, to the Department for any services or supplies provided under NMAP, except for those services or supplies provided before the suspension or termination.

2-002.05D Excluded Person: No clinic, group, corporation, or other association which is a provider of services shall submit claims for payment to the Department for any services or supplies provided by a person within the organization which has been excluded from participation in NMAP except for those services or supplies provided before the suspension or termination. If these provisions are violated by a clinic, group, corporation, or other association, the Department may suspend or terminate the organization and/or any individual person within the organization responsible for the violation.

A provider shall not submit any claims to NMAP that contain the costs of services provided by excluded persons.

2-002.05E Notification of Other Agencies: When a provider has been sanctioned, the Department shall notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

2-002.05F Notification of Local HHS Offices: When a provider's participation in NMAP has been suspended or terminated, the Department will notify the local HHS offices of the suspension or termination.

2-002.05G Provider Education: A provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include -

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction in the use and format of provider manuals;
5. Instruction in the use of procedure codes;
6. Key provisions of the Medicaid program;
7. Instructions on reimbursement rates; and
8. Instructions on how to inquire about coding or billing problems.

2-002.05H Denial of Enrollment: At the discretion of the Department, providers who have previously been terminated or suspended may or may not be re-enrolled as providers of Title XIX (Medicaid) services.

2-002.05J Reinstatement: At the end of the suspension period, the provider may request in writing that the Department reinstate his/her provider agreement. The Medicaid Division may approve or deny reinstatement of the provider agreement. The provider may be reinstated conditionally with a closed-end provider agreement or other restrictions or requirements.

2-002.06 Audits: All services for which claims for payment are submitted to the Department are subject to audit. During a review audit, the provider shall furnish to the Department, or its authorized representative, pertinent information regarding claims for payment. If an audit reveals that incorrect payments were made or that the provider's records do not support payments that have been made, the provider shall make restitution.

2-002.06A Sampling and Extrapolation: The Department's procedure for auditing providers may involve the use of sampling and extrapolation. Under this procedure, the Department selects a statistically valid sample of the services for which the provider received payment for the audit period in question and audits the provider's records for these services. All incorrect payments determined by an audit of the services in the sample are totaled and extrapolated to the entire universe of services for which the provider has been paid during the audit period. The provider shall pay to the Department the entire extrapolated amount of incorrect payments calculated under this procedure after notice and opportunity for hearing under 471 NAC 2-002.05 and 2-003.

2-002.06B Hearings: The Department shall allow the provider an opportunity to rebut the Department's audit findings. If the findings are based on sampling and extrapolation, the provider may present an independent 100% audit of his/her Medicaid payments during the audit period in lieu of accepting the Department's sampling and extrapolation. Any audit of this type must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with the Department's regulations. The provider must be prepared to submit supporting documentation to demonstrate this compliance.

2-003 Provider Hearings

2-003.01 Right to Appeal: Every provider of medical services has a right to appeal to the Director of the Department for a hearing on an action taken by the Department which has a direct adverse effect on the provider. Decisions of the medical review organization must first be reconsidered by the medical review organization. These actions may include but are not limited to, reductions or disallowances of claims, retroactive (year-end) adjustments, and administrative sanctions, including suspension or termination.

2-003.02 Request for a Hearing: A provider shall request a hearing within 90 days of the date of the action. Administrative sanctions must be appealed within 30 days of the date of the notice of the sanction. Requests for refunds must be appealed within 30 days of the date of the action. The date of the action is the original request date as indicated on the Refund Request Report MCP-248, or the date of the letter which notified the provider of the action.

2-003.02A Suspension or Termination: If the provider has been notified by the Department of a proposed suspension or termination, the provider may request a hearing before the effective date of the proposed suspension or termination, and the suspension or termination will not take effect until after the hearing decision has been made. If the provider requests a hearing after the suspension or termination has taken effect, the suspension or termination will remain in effect until after the hearing decision has been made.

2-003.03 Filing a Request: If the provider wishes to appeal an action of the Department, the provider must submit a written request for an appeal to the Director of the Department. The provider shall identify the basis of the appeal in the request.

2-003.04 Scheduling a Hearing: When the Director receives a request for a hearing, the request is acknowledged by a letter which states the time and date of the hearing.

2-003.05 Hearings: Hearings are scheduled and conducted according to the procedures contained in 465 NAC 6-000.

2-003.06 Long Term Care Facilities Appeals Process

2-003.06A Appeal of Denial, Termination, or Non-Renewal of Certification: Any nursing facility or intermediate care facility for the mentally retarded (ICF/MR) whose Medicaid certification has been denied, terminated, or not renewed may appeal to the Nebraska Department of Health and Human Services Regulation and Licensure (HHS Regulation and Licensure), which will conduct the hearings under Rule 56 of the Rules of Practice and Procedure adopted by HHS Regulation and Licensure.

2-003.06B Skilled Nursing Facility (SNF) Medicare/Medicaid Participation: If an SNF is participating, or seeking to participate, in both Medicare and Medicaid, and if the basis for the Department's denial, termination, or non-renewal of participation in Medicaid is also a basis for denial, termination, or non-renewal in Medicare, the facility is entitled to the review procedures specified for Medicare facilities under 42 Code of Federal Regulations (CFR) Part 405 Subpart O. The final decision entered under the Medicare review procedures will be binding for purposes of Medicaid NF participation. If the SNF is also certified for Medicaid NF participation, a separate appeal must be made to HHS Regulation and Licensure.

2-003.06C Appeal of Denial, Termination, or Non-Renewal of Medicaid Provider Agreements: Any NF or ICF/MR whose Medicaid provider agreement has been denied, terminated, or not renewed may appeal to the Director for a hearing under this section.

2-004 Client Lock-In: The Department investigates clients who through utilization review, provider referral, or local office referral are identified as misutilizing medical assistance services. If the investigation establishes that the client has abused or overutilized services provided through the Nebraska Medical Assistance Program, the client may be locked-in. The Department's Utilization Review Committee makes the decision to lock-in a client.

2-004.01 Definition of Lock-In: Lock-in is a method used by the Department to ensure appropriate utilization of medical services by a client who has been determined to be abusing or overutilizing services provided by NMAP without infringing on the client's free choice of a provider.

2-004.02 Lock-In Categories: The client may be locked-in to one of the following categories: Note: Payment for medical emergencies and referrals to other physicians may be covered under 471 NAC 2-004.04.

2-004.02A Category 1: One pharmacy. The client chooses one pharmacy. The Department will approve payment for prescriptions only from that pharmacy. Other covered services are not restricted.

2-004.02B Category 2: One primary physician and one pharmacy. The client chooses one primary physician and one pharmacy.

2-004.02C Category 3: One primary physician, one pharmacy, and one hospital. The client chooses one primary physician, one pharmacy, and one hospital for outpatient services. Inpatient hospital admissions are exempt.

2-004.02D Category 4: One prescribing physician and one pharmacy. The client chooses one prescribing physician and one pharmacy. Only prescriptions authorized by the prescribing physician and dispensed by the pharmacy will be approved for payment. This category allows the client to visit other physicians without restriction.

2-004.02E Category 9: All types of service. The client must choose only one provider for each type of service s/he wishes to receive.

2-004.03 Choice of Lock-In Provider(s): The client is allowed to choose the provider(s). The primary physician or the prescribing physician must be an individual, as opposed to a partnership, clinic, teaching institution, or hospital staff.

A client in the lock-in program who is enrolled in the Nebraska Health Connection is allowed to choose his/her provider. The provider chosen as the lock-in provider must be the provider who is the client's primary care physician (PCP) under NHC.

2-004.03A Change of Primary Provider: The choice of provider(s) may be changed at any time upon demonstration by the client of good cause, which is determined by the Utilization Review Committee. The client is allowed to change the provider(s) every three months without demonstration of good cause. All requests for change must be submitted to the Utilization Review Committee through the local office by submitting a revised Form MC-66, "Recipient Choice of Provider Agreement."

2-004.04 Services by Other Providers: Claims for services provided to a lock-in client by other than the chosen provider(s) will not be approved, with the following exceptions:

2-004.04A Medical Emergencies: Emergency care is defined as medically necessary services provided to an individual who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions. The provider shall document in writing any emergency situation. The documentation must be attached to any claim submitted to the Department.

2-004.04B Primary Physician Referrals: A primary physician may make a written referral of a lock-in client to another physician, dentist, osteopath, or podiatrist. Claims submitted may be approved for payment if a copy of the written referral from the primary physician is attached to the claim. Lock-in referrals may be approved for a reasonable amount of time for the condition being treated. If this time is exceeded, the Department may require a new referral letter from the primary physician.

2-004.04C Other Medical Services: Services by providers other than physicians, osteopaths, dentists, and podiatrists do not require a written referral from the primary physician.

2-004.05 Lock-In Notification: The Utilization Review Committee notifies the client, the client's local office, and Nebraska Health Connection (NHC) if the client is participating in NHC (or current enrollment broker for managed care) of the lock-in restriction through Form MC-38 at least ten days before imposing lock-in. Form MC-38:

1. Explains the lock-in restriction, stating that the restriction does not apply to emergency services furnished to the client;
2. Provides reasons for the lock-in;
3. Provides appropriate manual references;
4. Informs the client and local office of the client's right to an appeal hearing; and
5. Explains that the client has 90 days to request a hearing in writing, and that if the client requests a hearing in writing within 10 days, the Lock-In will be delayed until a hearing decision is rendered.

2-004.05A Client Appeal Rights: The lock-in client has the right to appeal for a hearing. The client or the client's representative has 90 days following the date of notification to request a hearing in writing. If a hearing is requested in writing within ten days following the date of notification, the lock-in restriction will be delayed until a hearing decision is rendered.

2-004.06 Lock-In Agreement: Within ten working days following the date of the lock-in notification, the local office, NHC or client shall submit Form MC-66, "Recipient Choice of Provider Agreement," (see 471-000-93) to the Utilization Review Committee. The client and witness shall sign the agreement. The agreement identifies the provider(s) chosen by the client and states that the chosen provider(s) will be the only provider(s) of service.

2-004.06A Failure to Provide Agreement: Failure by the lock-in client or the local office to provide the agreement will result in the Department designating the provider(s) for the client or restricting the eligibility of the client to "emergency services only" (see 471 NAC 2-004.07).

2-004.06B Effective Date of Lock-In Agreement: The effective date of the lock-in agreement is either: 1) The first day of the month following the month in which the client signed the agreement; or 2) The date the agreement is signed, if requested by the lock-in client, caseworker or NHC and approved by the state; or 3) Another date, if requested by the lock-in client, caseworker or NHC and approved by the state.

2-004.07 Eligibility Information: Lock-in status may be verified by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580) (see 471-000-124); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128), or electronically by using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271).

If "emergency services only" is indicated, the provider may render only emergency services. The provider shall document in writing any emergency situation and the documentation must accompany any claim submitted to the Department for payment.

2-004.07A Provider Determination of Lock-In Status: The provider shall determine the client's lock-in status by accessing the Department Internet Access for Enrolled Providers (www.dhhs.ne.gov/med/internetaccess.htm); the Nebraska Medicaid Eligibility System (NMES) at 800-642-6092 (in Lincoln, 471-9580); the Medicaid Inquiry Line at 877-255-3092 (in Lincoln 471-9128); or electronically by using the standard Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). NMES will allow the provider to obtain current eligibility information (including lock-in status) and is operational 24 hours per day, seven days per week. (See 471-000-124 for instructions on using NMES.)

When a client initially becomes eligible for medical assistance, s/he may not have a Medicaid Identification Card at the time of the appointment. The provider shall verify the eligibility of the client(s) by contacting one of the eligibility verification systems listed above or the local office, or by using the standard electronic transaction.

2-004.08 Pharmacy Claims: Pharmacy claims submitted for prescriptions dispensed to a lock-in client by providers other than those designated on the Nebraska Medicaid Eligibility System may not be paid except in a bona fide emergency. The pharmacy shall document in writing the emergency situation.

Due to the circumstances necessitating the lock-in, the Department will approve for payment only prescriptions authorized by the primary or prescribing physician. Prescriptions by other practitioners (dentist, podiatrist, referral physician, etc.) will not be approved unless the primary or prescribing physician authorized them.

2-004.09 Client's Lock-In File: The Utilization Review Committee maintains a complete case file for each lock-in client at the Central Office. The client or the client's representative may request in writing a copy of all information contained within this file.

2-004.10 Review of Lock-In Status: The Utilization Review Committee, or its designee, will review the client's lock-in status every 24 months on the continued appropriateness of the lock-in.

At least 10 days before lock-in is extended, the Utilization Review Committee notifies the client, the client's local office, and Nebraska Health Connection if the client is participating in NHC (or current enrollment broker for managed care) of the review of the client's lock-in status. The notice:

1. Explains the outcome(s) of the review, which may include continuing lock-in status for another 24 months, changing lock-in category (see 471 NAC 2-004.02), or removing lock-in status;
2. Provides reasons for the outcome(s), according to the criteria listed in 471 NAC 2-004.10A;
3. Provides appropriate manual references;
4. Informs the client, local office and NHC of the client's right to an appeal hearing; and
5. Explains that the client has 90 days to request a hearing in writing, and that if the client requests a hearing in writing within 10 days, no change will be made until a hearing decision is rendered.

2-004.10A: The client's lock-in status may be continued, changed or removed following the review of lock-in status based on the following reasons:

1. Use of controlled substances, carisoprodol, tramadol or other drug(s) with abuse potential; or
2. Early prescription refills, as defined in the drug claim processing system; or
3. Use of drugs which are known to interact with other drugs, diseases, conditions or foods; or
4. Use of medications indicating multiple medical conditions with complex medication regimens; or
5. Patient safety, including use of medication(s) with narrow therapeutic index;
6. Abuse or overuse of medical services; or
7. History of drug abuse, medication-seeking behavior, non-compliance, emergency room overuse or abuse; or
8. Coverage by Medicaid of services from non-lock-in providers in non-emergency situations; or
9. Report(s) of obtaining Medicaid coverable drugs by paying cash; or
10. Other similar reasons.

In addition to the biennial review, the client or the client's primary physician may request a review of the client's lock-in status. Any request for review must contain a statement from the client's primary physician indicating that the client's medical history and/or treatment plan has been completely reviewed and stating the change in lock-in status being recommended, along with reasons supporting this recommendation. The Utilization Review Committee will notify the lock-in client, local office and NHC, if the client is participating in NHC, of its decision within ten days from the date the request is received. Requests for review of lock-in status will be limited to once per year, unless the client can demonstrate good cause. Good cause will be determined by the Utilization Review Committee.

2-005 Advance Directives: An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (statutory or as recognized by the courts of the state) that relates to the provision of medical care if the individual becomes incapacitated.

All Medicaid-participating hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations, and health insuring organizations shall comply with this section. They shall -

1. Maintain written policies, procedures, and materials concerning advance directives;
2. Provide written information (see 471-000-304) to all adult (as defined by state law) individuals receiving medical care by or through the provider or organization concerning their rights under state law to -
   a. Make decisions concerning their medical care;
   b. Accept or refuse medical or surgical treatment; and
   c. Formulate advance directives, such as living wills or durable power of attorney for health care;
3. Provide written information to all adult individuals on the provider's policies concerning implementation of these rights;
4. Document in the individual's medical record whether the individual has executed an advance directive;
5. Not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive;
6. Ensure compliance with requirements of state law (whether statutory or as recognized by the courts of the state) concerning advance directives; and
7. Provide for educating staff and the community on advance directives.

2-005.01 When Providers Give Information Concerning Advance Directives: Providers shall give information concerning advance directives to each adult patient as follows:

1. A hospital shall give information at the time of the individual's admission as an inpatient;
2. A nursing facility shall give information at the time of the individual's admission as a resident;
3. A provider of home health care or personal care services shall give information to the individual in advance of the individual's coming under the care of the provider;
4. A hospice program shall give information at the time of initial receipt of hospice care by the individual; and
5. An HMO/HIO shall give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or re-enrolls the individual. If an HMO has more than one medical record for its enrollees, it must document all medical records.

2-005.02 Information Concerning Advance Directives at the Time an Incapacitated Individual Is Admitted: An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether s/he has executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it shall also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once s/he is no longer incapacitated.

2-005.03 Previously Executed Advance Directives: When the patient or a relative, surrogate, or other concerned or related individual presents the facility with a copy of the individual's advance directive, the facility shall comply with the advance directive to the extent allowed under state law. This does not preclude a facility from objecting as a matter of conscience, if it is permitted to do so under state law.

Absent contrary state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether s/he has executed an advance directive, the facility shall note that the individual was not able to receive information and was unable to communicate whether an advance directive existed.

2-006 Disclosure of Information by Providers: Under 42 CFR 455, Subpart B, the Department requires that providers disclose information on -

1. Ownership and control;
2. Business transactions; and
3. The providers' owners and other persons convicted of crimes against Medicare, Medicaid, or Title XX (Social Services Block Grant) programs.

2-006.01 Ownership and Control: Providers are required to disclose -

1. The name, address, Employer Identification Number or social security number of:
   a. Each person with an ownership or control interest in the entity or any subcontractor in which the provider directly or indirectly has a five percent or more ownership interest; and
   b. Any managing employee of the entity;
2. Whether any of the persons named in compliance with the above paragraph is related to another as spouse, parent, child, or sibling; and
3. The name of any other entity in which a person named in 471 NAC 2-006.01(1) has an ownership or controlling interest.

For purposes of this section, "person with an ownership or control interest" means, with respect to an entity, a person who:

1. (a) Has directly or indirectly an ownership interest of five per centum or more in the entity;
   (b) Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds five per centum of the total property and assets of the entity; or
2. Is an officer or director of the entity, if the entity is organized as a corporation; or
3. Is a partner in the entity, if the entity is organized as a partnership.

The term "managing employee" means, with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

Any provider that is subject to periodic survey and certification of its compliance with Medicaid standards shall supply this information to the Department at the time it is surveyed. Any provider that is not subject to periodic survey and certification shall supply the information before entering into an agreement with the Department.

The Department shall not approve a provider agreement, and shall terminate an existing agreement, if the provider fails to disclose ownership or control information. The Department shall not pay a provider who fails to disclose ownership or control information.

A provider shall notify the Department of any changes or updates to the information supplied under 471 NAC 2-006.01 not later than 35 days after such changes or updates take effect.

2-006.02 Business Transactions: When requested, providers shall disclose, within 35 days of the date on the request, full and complete information on -

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending with the date of the request; and
2. Any significant business transaction between the provider and any wholly-owned supplier, or between the provider and any sub-contractor, during the five-year period ending on the date of the request.

The Department shall not pay providers who fail to comply with a request for this information, or pay for services provided during the period beginning on the day following the date the information was due to the Department and ending on the day before the date the Department received the information.

2-006.03 Persons Convicted of Crimes: Before the Department enters into or renews a provider agreement, or upon request, the provider shall disclose to the Department the identity of any person who -

1. Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
2. Has been convicted of a criminal offense related to that person's involvement in any problem under Medicare, Medicaid, or the Social Services Block Grant (Title XX) programs since the inception of those programs.

The Department may refuse to enter into or renew a provider agreement if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Social Services Block Grant (Title XX). The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately disclose this information.